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Western Gap Application and Amendment Form

IMPORTANT NOTE: Please complete and sign this form and return to your Broker who will submit to Kaelo on your behalf. Kaelo will only accept applications received by a Broker. Applications received after the 15th of the current month will only activate the 1st of the following month.

A Application Status:

○ **New Application:**

- ○ I would like to join in my private capacity
- ○ I would like to join via my employer

If you have Gap Cover with another provider but wish to transfer to Western Gap, please submit your proof of cover. Waiting periods may apply.

For new applications, please complete all sections of this form.

○ **Transfer:**

- ○ I am currently a Western Gap Policyholder, but I am leaving my employer and wish to continue with my Policy in my private capacity.
- ○ I am currently a Western Gap Policyholder but wish to transfer my cover to my employer.
- ○ I am currently a Western Gap Policyholder but wish to change my plan.

Current Policy Number: ______________________

Please complete Section C, F, G and I. If there have been any changes to your details, please update them in the relevant sections.

○ **Amendments to an existing Policy:**

Current Policy Number: ______________________

For all amendments / updates please complete the relevant section that you are amending as well as completing the Broker Details Section and the Declaration Section.

B Application Details:

Cover Start Date: ______________________

Policy Type:

○ Single Policy

If you are joining as a single Policyholder, you accept that cover will only apply to yourself and that should any changes be required you will notify Kaelo within 31 days. This includes the addition of Dependants.

○ Family Policy

If you are joining as a Family, you accept that cover will apply to you, your Spouse and your Children up to the maximum age of 26. Should any changes be required you will notify Kaelo within 31 days. This includes the addition or removal of Dependants.

If you are joining through your employer, only the premium options agreed with your company will be available to you.

Plan Type:

- ○ Gap
- ○ Gap Plus
- ○ Gap Select
- ○ LPE

This is not a Medical Scheme and the cover is not the same as that of a Medical Scheme. This Policy is not a substitute for Medical Scheme membership.
Kaelo Risk (Pty) Ltd is an authorised financial services provider (FSP 36931).
This product is underwritten by Western National Insurance Company Limited (FSP 9465).

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C Policyholder Details:

Personal Details:

First Name: ______

Surname: ______

ID Number: ______ Date of Birth: ______

Gender: ______ Cellphone: ______

Telephone: ______ Email: ______

Postal Address: ______

Medical Scheme Details:

Medical Scheme: ______ Medical Scheme Number: ______

Plan: ______

Employer Details:

If you are applying as part of an employer group, please complete the below section.

Employer Name: ______

Branch Name: ______

Date of Employment: ______ Employee Number: ______

D Dependant Details:

Select one of the following:

- ○ Addition of Dependants on a new application
- ○ Addition of Dependants to an existing Policy
- ○ Removing Dependants
- ○ Updating / amending Dependants details

Should you have more than three Dependants, please complete a second form and submit the forms together.

Dependant Number:	1	2	3
Surname:			
Full Name:			
ID Number:			
Cellphone:			
Email:			
Relationship:			
Inception / Start Date:			
End Date if removal of Dependant/s:			

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E Health Declaration:

In answering the questions below, consider any dental treatment, Family planning, consultations with any Doctors, existing ailments and/or prescribed chronic medicine.

1. Are you or your Dependants aware of any reason that you or anyone on the Policy may require hospitalisation or cancer Treatment within the next 12 months? Yes No
2. Have you or any of your Dependants received any medical advice within the last 12 months? Yes No
3. Have you or any of your Dependants consulted with any Doctors within the last 12 months? Yes No
4. Do you or any of your Dependants have any existing medical conditions? Yes No
5. Are you or any of your Dependants currently pregnant or planning to become pregnant? Yes No

If you have answered yes to any of the questions in the health questionnaire, please provide the full details in the space provided below:

Question Number	Name	Details of Condition/Treatment/ Disorder	Last Date of Consultation	Details of Future Treatment

F Debit Order Details:

If you are joining in your private capacity or you are responsible for the payment of your Premium as part of an employer group, please complete the below section. If your employer is contributing the premium on your behalf, please do not complete this section.

- New Policy
- Change in banking details

Account Name: ______________________ Account Number: ______________________

Branch Name: ______________________ Bank Name: ______________________

Account Type: ______________________ Bank Code: ______________________

Debit Order Date: ◯ 1st ◯ 7th ◯ 20th Premium: ______________________

Name and Surname of Premium Payer: ______________________

Signature: ______________________

Please note Premiums are due in advance

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G Broker Details:

Name: Tyrone
Surname: Raman
Broker House: Rob Mitchell Brokers
Broker House Code:
FSP Number: 31569
Cellphone: 076 9444 542
Email: tyrone@coverthegap.co.za

If applicable, the Broker Fee form must be read in conjunction with this application form.

H Additional Documents:

Please ensure that the following documents are submitted with your application or amendments.

- A clear copy of either the ID or Birth Certificate of all Insured Parties being registered.
- A clear copy of the Medical Scheme Membership Certificate is required.

I Declaration:

I, ____ (full name) hereby declare that this application form, whether in my handwriting or not, is accurate and complete and forms the basis of the contract of insurance between the Underwriter and myself.
I hereby apply for the insurance product/s and agree to abide by its Policy rules and/or those of its Underwriter and any amendments thereto which may be made from time to time. I confirm that all the information provided herein is complete and true and that I have not concealed any relevant or pertinent information that may affect the evaluation of risk considered under this Policy of cover.
I understand that the provision of any false, misleading or missing information could result in my application being rejected or my Policy being cancelled or claims being rejected. Should this occur, I agree to refund all Benefit payments that I have received in relation to this Policy of insurance.

I hereby provide irrevocable authority for Kaelo and its Underwriter to obtain any of my or my beneficiaries' medical history from any Medical Service Provider, Medical Scheme, insurance company or healthcare broker for the purposes of assessing this application for insurance as well as the underwriting of any future risk or the assessment of any claim that relates to this insurance cover.

Premiums due to Western are payable monthly. Premiums that are in arrears will result in my Policy being suspended or possibly terminated. In the event that any Policy Benefit becomes payable subsequent to or as a result of my death, I hereby provide an irrevocable authority for such Benefits to be paid directly to my surviving Spouse or failing such circumstance to the nominated guardians or trustees responsible for the future care of my minor Children or failing either of the preceding events to my estate. Where applicable, I hereby authorise Western to draw against the above bank account all amounts due to Western in terms of this insurance cover. Should the relevant Premiums be adjusted by the Underwriters, I hereby confirm that the adjusted amount may be drawn from the above account subject to the notice period outline in the Policy. This request is to remain in force unless cancelled by one month's written notice. Where my employer deducts the Premium from my salary. I hereby provide authority for my employer to deduct such Premium and pay this across to Western. I accept that any notice given to my employer is deemed to have been given to me.

Signature: ______________________ Date: ______________________

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